INSURE MONTANA

2009 Renewal Application Form

Purchasing Pool Program or Tax Credit Program

Please complete and return to: **Insure Montana**
840 Helena Avenue
Helena, MT 59601
Fax: 406-444-3497

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To remain eligible for the Insure Montana program, please read over carefully the following information, make any necessary changes, and return the form to the Insure Montana office before October 31, 2008. For businesses participating in the Purchasing Pool Program, all employees participating in the group health plan must also submit an Employee Renewal form to report of their family's annual gross income as instructed in the cover notice with this form. **If a Renewal Application is not received by October 31, 2008, your business no longer qualifies for the Insure Montana program effective December 31, 2008 and you will be required to reapply for the program for future assistance**. ******Please contact Insure Montana staff at 1-800-332-6148 for questions concerning this application.******

Demographic Information

Legal Name of Business	Type of Entity (Corp, LLC, S-Corp, etc.)	Business Start Date	Federal Tax ID Number
Contact Name and Title	Owner's Name	Company Name to Appear on Statement	Type of Business
Address	City	State	Zip Code
Mailing Address if Different	City	State	Zip Code
Telephone	Fax	**Email Address*** (please print clearly)	State Tax ID
Please List Any Additional Business Owner(s)			

***Do you want the business Electronic Fund Transfer notice by E-mail? □YES □NO**

*"**Eligible Employee**," means any employee who works on a full-time basis with a normal workweek of 30 hours or more, except that at the sole discretion of the employer, the term may include an employee who works on a full-time basis with a normal workweek of between 20 and 30+ hours as long as this eligibility criteria is applied uniformly among all of the employer's employees.

Please answer the following questions:

1. How many employees/owners does this business employ? _____

2. How many eligible employees/owners* does this business employ? _____

3. How many eligible employees/owners* participate in the business' group health insurance plan? _____

4. If applicable, please fill out the related employer information below (A related employer may be any other business owned by the owners of this business or a family member of the owners, including parent, spouse, child or sibling.).

Please list the business name of any related employers	Federal Tax ID Number

Please include the following information for all related employers (in addition to applicant's employees)

Number of Employees	Estimated Number of Eligible Employees*

5. Do any of your employees or employees of a related employer earn over $75,000 gross wages, including bonuses and commissions, (before taxes) per year (excluding owners)? Yes ___ No ___

5a. List all business owners participating in the health plan that earn over $75,000 gross wages, including bonuses and commissions, (before taxes) per year:_____

6. Does your firm or any related employers have delinquent state income tax liability owing to the Montana Department of Revenue from previous years? Yes ___ No ___

7. What percentage of the employee-only premium does this business contribute to its employees? _____

If 100%, does the business also contribute 100% to dependent coverage? Yes ___ No ___

Health Insurance Policy Information

Insurance Company:
Policy Number:

Please make any changes to the following employees' information. If the employee is no longer on the health insurance policy, please indicate the date he/she was removed from the policy beside his/her information.

Employee #1 Name:
Date of Birth:
Employee Premium:
Employer Contribution:
Date removed from policy:

Employee Portion:
Employer Contribution to Spouse:
Employer Contribution to Dependents:
Total Number of Dependents:

Employee #2 Name:
Date of Birth:
Employee Premium:
Employer Contribution:
Date removed from policy:

Employee Portion:
Employer Contribution to Spouse:
Employer Contribution to Dependents:
Total Number of Dependents:

Employee #3 Name:
Date of Birth:
Employee Premium:
Employer Contribution:
Date removed from policy:

Employee Portion:
Employer Contribution to Spouse:
Employer Contribution to Dependents:
Total Number of Dependents:

Employee #4 Name:
Date of Birth:
Employee Premium:
Employer Contribution:
Date removed from policy:

Employee Portion:
Employer Contribution to Spouse:
Employer Contribution to Dependents:
Total Number of Dependents:

Employee #5 Name:
Date of Birth:
Employee Premium:
Employer Contribution:
Date removed from policy:

Employee Portion:
Employer Contribution to Spouse:
Employer Contribution to Dependents:
Total Number of Dependents:

Employee #6 Name:
Date of Birth:
Employee Premium:
Employer Contribution
Date removed from policy:

Employee Portion:
Employer Contribution to Spouse:
Employer Contribution to Dependents:
Total Number of Dependents:

Health Insurance Policy Information (Cont'd)

Employee #7 Name:
Date of Birth:
Employee Premium:
Employer Contribution:
Date removed from policy:

Employee Portion:
Employer Contribution to Spouse:
Employer Contribution to Dependents:
Total Number of Dependents:

Employee #8 Name:
Date of Birth:
Employee Premium:
Employer Contribution:
Date removed from policy:

Employee Portion:
Employer Contribution to Spouse:
Employer Contribution to Dependents:
Total Number of Dependents:

Employee #9 Name:
Date of Birth:
Employee Premium:
Employer Contribution:
Date removed from policy:

Employee Portion:
Employer Contribution to Spouse:
Employer Contribution to Dependents:
Total Number of Dependents:

New employees added to the health insurance policy not included above:

Employee Name:
Date of Birth:
Employee Premium:
Employer Contribution:
Employee Portion:

Employer Contribution to Spouse:
Employer Contribution to Dependents:
Total Number of Dependents:
Effective Date on Policy:

Employee Name:
Date of Birth:
Employee Premium:
Employer Contribution:
Employee Portion:

Employer Contribution to Spouse:
Employer Contribution to Dependents:
Total Number of Dependents:
Effective Date on Policy:

Employee Name:
Date of Birth:
Employee Premium:
Employer Contribution:
Employee Portion:

Employer Contribution to Spouse:
Employer Contribution to Dependents:
Total Number of Dependents:
Effective Date on Policy:

I certify, under penalty of law, that all my answers are correct and complete to the best of my knowledge. I understand the penalty for withholding or giving false information which may include a possible criminal offense (MCA 33-22-2009). I agree to provide documents to verify information on this application if requested. I understand that State staff may obtain documents and/or information to verify statements on this application. I understand that I must provide all participating employees with an Employee Application form and instructions to submit the form with income information to the Insure Montana program.

Employer Signature _____ **Date** _____